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Draft country programme document***

Zimbabwe

Summary

The Executive Director presents the draft country programme document for Zimbabwe for discussion and comments. The Executive Board is requested to approve the aggregate indicative budget of $3,850,000 from regular resources, subject to the availability of funds, and $14,000,000 in other resources, subject to the availability of specific purpose contributions, for the period 2005 to 2006.

* Submission of the present document was delayed by necessary consultations with the UNICEF country office.
** E/ICEF/2004/8.
*** In accordance with Executive Board decision 2002/4 (E/ICEF/2002/8), the present document will be revised and posted on the UNICEF web site in October 2004, together with the summary results matrix. It will then be approved by the Executive Board at its first regular session of 2005.

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Basic data (2002 unless otherwise stated)	
Child population (millions, under 18 years)	6.6
U5MR (per 1,000 live births)	123
Underweight (% moderate and severe, 2003)	17
Maternal mortality ratio (per 100,000 live births, 1995-1999)	700*
Primary school enrolment (% net, male/female, 2000)	80/80
Primary schoolchildren reaching grade 5 (%, 1999)	94
Use of improved drinking water sources (%, 2000)	83
Adult HIV prevalence rate (%, 2003)	24.6
Child work (%, children 5-14 years old)	...
GNI per capita (US$)	**
One-year-olds immunized against DPT3 (%)	58
One-year-olds immunized against measles (%)	58

* The WHO/UNICEF/UNFPA estimate for MMR is 1,100 per 100,000 live births for the year 2000. This estimate is adjusted for misclassification and underreporting.

** Estimated range $735 or less.

The situation of children and women

1. Zimbabwe is experiencing a reversal of progress made in assuring the health and well-being of its children and women, according to the draft Common Country Assessment (CCA), the Millennium Development Goals report on Zimbabwe and other reports. Though gaps exist in recent data, several trends are clear. Life expectancy, for example, dropped from 61 years during the early 1990s to 43 years in 2001, and is projected to decline to 35 years by 2005. Between 1989 and 1999, infant and under-five mortality rates rose from 40 to 65 per 1,000 live births, and from 59 to 102 per 1,000 live births, respectively. The maternal mortality ratio, a measure of the robustness of the health services, deteriorated from 283 per 100,000 live births in 1994 to 685 per 100,000 live births in 1999. To put Zimbabwe back on track towards achieving the Millennium Development Goals, it is critical to continue to support effective programmes for improving the situation of children and women.

2. The immediate causes of the high mortality and reversal of progress are a combination of preventable diseases and malnutrition. An increase in the disease burden is exemplified by a resurgence of epidemics of malaria, cholera, dysentery and tuberculosis. Prevention of malaria has been made more difficult by population movements from non-endemic to endemic areas. Two million cases of malaria are reported annually, and there is an increase in mortality from the disease. Immunization, which had reached universal levels by 1990, dropped sharply after 1997. Routine DPT3 coverage dropped from 83 per cent in 1995 to 47 per cent in 1999. Recurrent cholera epidemics in some districts imply a decline in hygiene as well as the coverage and quality of water and sanitation. Nearly half of rural boreholes are non-functional.

between 13 and16 per cent. However, according to a Demographic Health Survey, from 1999 to 2003, the level of underweight increased from 14 to 17 per cent. Wasting increased from around 1 per cent in 1988 to 6 per cent in 1996, a level that appears to have stagnated throughout the humanitarian crisis, with reported levels of wasting remaining at 5 per cent (Ministry of Health/UNICEF 2003). Along with low birthweight, vitamin A and iodine deficiencies and iron deficiency anaemia also remain significant public health concerns. Poor feeding practices, the HIV/AIDS epidemic, the orphan crisis and a reduction in caring capacity exacerbate the high levels of severe malnutrition found in Zimbabwe.

4. The underlying causes of high malnutrition, morbidity and mortality are food insecurity, and deteriorating social services and caring capacities at all levels. Formerly a net exporter of food, Zimbabwe has received food aid since 2002 because of a combination of consecutive years of drought, the HIV/AIDS epidemic and unintended effects of land reform. The number of food-insecure people averages about 5 million to 7 million, of whom about 60 to 70 per cent are children and women. In urban areas, an increase in food insecurity is linked to an increase in poverty. A 2004 urban vulnerability assessment showed a doubling of urban poverty since 1995, with about 2.5 million urbanites being food-insecure. The assessment identified the greatest livelihood shocks to food security as inflation, high cost of services, unemployment, high taxes, deaths, illnesses and hospital costs.

5. Declining infrastructure and public expenditures, combined with a high attrition of human resources, have severely eroded public health and education systems. These two sectors are characterized by shortages of essential supplies, reduced accessibility by the poor, low motivation of staff and weakened planning and management capacities. Health has seen the highest erosion of human resources, attributable to 'brain drain' and AIDS mortality. For example, the vacancy rate in the1,530 posts for doctors is 55 per cent, and in the 11,640 posts for nurses is 40 per cent. With AIDS patients occupying up to 70 per cent of hospital beds, the strain on the health services is enormous, making it difficult for the Ministry of Health to maintain critical services, including outreach and response to epidemics.

6. AIDS is the first killer disease among both adults and children, with an estimated 3,290 people (2,600 adults and 690 children) dying of AIDS per week in 2003. Over 90 per cent of children with HIV became infected through parent-to-child transmission, whereas most adults became infected through heterosexual sex. Girls and women make up nearly 80 per cent of young people aged 15-24 who are infected with HIV. Adult HIV prevalence has soared in the last several decades, increasing from less than 1 per cent in 1983 to around 25 per cent in 2003, according to 2003 statistics of the Ministry of Health, Centers for Disease Control and Prevention in the United States, and UNAIDS. The trend is levelling off, thanks largely to the political commitment of the Government, which declared HIV/AIDS a national disaster and arranged for a tax levy of 3 per cent to be collected from salaries of civil servants and set aside for HIV/AIDS activities through the National AIDS Council. Nevertheless, the scale of the epidemic remains worrisome. Of the more than 1.82 million people infected in 2003, about 1.54 million were adults 15-49 years of age and 165,000 were children under 14 years of age. Women made up 56.5 per cent of the adults, and children under 14 years made up 9 per cent of the total number. Unequal power relations between men and women fuel the disease, especially through intergenerational transmission. Estimates indicate that about 67

per cent of young women aged 15-24 years have sex with men 5 to 10 years older, and more than one in five women aged 15-29 reported having had forced sex.

7. The most devastating effect of the disease has been the orphaning of generations of children. Of the estimated 1 million orphans in Zimbabwe in 2003, about 761,000, or 75 per cent, have been orphaned by AIDS, a number projected to surpass 1.3 million by 2005. This figure excludes about 20 per cent of orphans in the 15-17 year age group not included in current statistics. Orphans will account for over 20 per cent of children by 2010, compared with a current figure of about 15 per cent, according to a 2003 projection by UNICEF. On average, about 2 per cent of orphans are below 1 year old, 15 per cent below 4 years old, 35 per cent 5 to 9 years old and 50 per cent 10 to14 years old. Most orphans live in the rural areas because parents tend to migrate back to their home villages when they are sick. Though communities absorb most orphans through an extended family system that is already overstretched, many orphans are under the care of poor grandparents, abusive relatives and foster parents, or older siblings. Because of the size of the problem, households that take in orphans are more likely to become poorer because of the increase in the number of dependants relative to caregivers, a ratio estimated to average 2.2, compared with 1.4 in non-orphan households with children.

8. Children orphaned by AIDS are more likely to suffer from damaged psychosocial development because of the stress of watching parents die slowly from the disease, separation from relatives and the powerful stigma and discrimination associated with the disease. These children are also less likely to have a birth certificate, go to school and access health or water and sanitation services. At the same time, such children are more likely to be malnourished, food-insecure and sick, and to live or work on the streets and be subjected to the worst forms of abuse. Orphans are also more likely to be excluded from inheritance of property because of a lack of official wills. Analysts estimate that 25 per cent of all children live with at least one HIV-positive parent who is unable to access antiretroviral (ARV) treatment.

9. Several important gains made in education in the 1990s are being eroded. By 2000, the net enrolment ratio in Zimbabwe nad climbed to 92 per cent, and the literacy rate for those aged 15-24 had reached 98 per cent. Enrolment was marked by gender parity. These results were largely due to policies promoting free and compulsory primary education, including the 1987 Education Act on free education. However, the introduction of fees and levies in the 1990s, combined with the current complex emergency, counteracted the positive effects of the free education policy. Since 2000, enrolment has dropped by about 30 per cent, from 95 to 67 per cent for boys, and from 90 to 63 per cent for girls. By 2000, completion rates that had peaked at 83 per cent in 1990 had declined to 75 per cent, with 10 per cent of girls not completing school, compared with around 5 per cent of boys. The rising costs of school fees, textbooks and uniforms, plus the impact of hunger and HIV/AIDS, has negatively affected enrolment, attendance and learning ability. The decline in education calls for new ways to address these issues. Policies such as recent plans to educate about 800,000 orphans and vulnerable children through the basic education assistance module need support.

10. The rapidly declining economy has also reversed Zimbabwe's social and economic gains. Despite several home-grown economic revival plans, per capita real GDP growth declined from a positive 5.5 per cent in 1990 to a negative 14.1 per

cent by 2003, with inflation reaching 600 per cent. This decline reduced the capacity for investing in children and key sectors. By 2003, poverty had increased from 40 per cent of people in the late 1980s to about 70 per cent, showing significantly higher levels in rural than urban areas and in households with chronically sick parents or headed by children, women and grandparents. To revitalize the economy, fundamental policy changes beyond the recent monetary policy and anti-corruption drive are needed.

11. Domestic political struggles, coupled with a disordered agrarian land reform, have compounded Zimbabwe's economic woes, led to political polarization, and strained relations with donor countries. International sanctions, combined with a withdrawal from development cooperation by the International Monetary Fund, the World Bank and most donors, have worsened prospects for recovery. Build-up to the March 2005 parliamentary elections is likely to heighten the current political tension. Although the issues of governance and human rights are contentious, the Government has reiterated as priorities the "promotion of key rights", particularly the rights of women and children, and support for the creation of an environment in which rights are promoted, protected and fulfilled.

12. Only 54 per cent ($24.8 million) of the total budget of $45.8 million approved by the Executive Board for the country programme was funded because of donor withdrawal. An additional $13.9 million came through the consolidated appeal process (CAP), bringing total other resources to about 85 per cent of budget.

Key results and lessons learned from previous cooperation, 2000-2004

Key results achieved

13. Despite constraints caused by underfunding, good progress was made in several areas with the cooperation of the following donors: Australia, Belgium, Canada/Canadian International Development Agency (CIDA)/the International Development Research Council, Centers for Disease Control and Prevention, Denmark, the European Commission Humanitarian Office (ECHO), Italy, Ireland, Japan, Netherlands, New Zealand, Norway, Micronutrient Initiative, Rotary International, South Africa, the Swedish International Development Cooperation Agency (SIDA), United Nations Foundation, United Kingdom/Department for International Development (DFID), the United States Agency for International Development (USAID) and several UNICEF National Committees.

14. Three results in particular deserve attention. First, the declining rates of immunization were reversed through efforts of the Ministry of Health and Child Welfare, the World Health Organization (WHO). UNICEF and other partners, with funds or assistance provided by various UNICEF national committees, CIDA, and the Global Alliance for Vaccines and Immunization and WHO. UNICEF contributed financial and technical assistance and provided the vaccines and related supplies. As a result of the combined efforts, routine coverage of DPT3 rose from 47 per cent in 1999 to 58 per cent in 2002. Moreover, support to special immunization days helped to achieve national measles coverage of 95 per cent and vitamin A supplementation of 90 per cent in 2002. In 2003, mop-ups in 16 underperforming districts achieved similar coverage rates.

15. Second, the nutrition situation was stabilized through supplementary and therapeutic feeding, with a rate of wasting of 5 per cent achieved. This effort of the Government was supported by the World Food Programme (WFP), NGOs and UNICEF, with funding provided by ECHO, DFID and Norway. UNICEF assistance reached over 770,000 children under five years old with supplementary feeding and nearly 4,500 children with therapeutic feeding.

16. Third, Zimbabwe's first National Plan of Action on Orphans and Vulnerable Children (OVC) was developed and adopted through the convening of a national conference. Technical support and funding from ECHO, Italy, the Netherlands, SIDA and various UNICEF National Committees helped to mobilize partners and stakeholders, including children, to create the plan and initiate its implementation.

Lessons learned

17. The major lesson learned is that the human rights-based approach to programming applied in Zimbabwe developed the capacities of communities to better mobilize their resources and make use of external assistance in responding to the humanitarian situation. Pre-emergency development of community action plans that had identified the needs of high-risk groups, as well as the introduction of village registers and vulnerability maps, had created awareness of the rights, obligations and roles of village leaders and families, and had made it easier to organize local mobilization for response.

18. Another important lesson learned is the usefulness of using community-level lessons and best practices to influence national-level policies and strategies. The empowering nature of the community centred capacity development approach and its success in mobilizing for community social action convinced the Government to initiate a review of its decentralization strategy to include greater community participation through the Rural Development Councils and in the formulation of the National Plan of Action for OVC.

The country programme, 2005-2006

Summary budget table

(In thousands of United States dollars)*

Programme	*Regular resources*	*Other resources*	*Total*
Health, nutrition and environment	800	4 000	4 800
Child learning and lifeskills	590	3 200	3 790
Child protection	460	4 000	4 460
HIV/AIDS and young people development	700	2 400	3 100
Cross-sectoral costs	1 300	400	1 700
Total	**3 850**	**14 000**	**17 850**

* Additional funding expected from Consolidated Appeals for 2005/2006.

Preparation process

19. The process involved Government counterparts, other United Nations agencies, civil society, donors and young people under coordination of the Ministry of Finance. Midterm, annual and end-of-programme cycle reviews, including a joint United Nations Development Assistance Framework (UNDAF) midterm review and updated analyses on the situation of children, were followed by the development of the draft CCA and UNDAF through high-level United Nations consultations with the Government. Other critical processes were the development of the Millennium Development Goals report and the Consolidated Appeal Process (CAP). A desktop environmental assessment screening of the programme was also done.

Goals, key results and strategies

20. The country programme places OVC and HIV/AIDS at its centre. All programme components integrate into their strategies and activities the prevention of HIV and orphanhood, and the survival, protection, and development of OVC as well as care and mitigation for those suffering from HIV/AIDS. Orphans are defined as children below 18 years who have lost one parent (single orphans) or both parents (double orphans). Other vulnerable children include those who are HIV positive or have parents living with HIV/AIDS, children from very poor families, and those who are disabled, have been abused or are living on the street.

21. The country programme goal is to promote every Zimbabwean child's right to access quality health services and basic education while benefiting from equity and protection. A special focus is placed on OVC and HIV/AIDS.

22. The overarching country programme strategy is to develop the capacities of those responsible for the care and well-being of children, from the community to the national level, to respect, promote, protect and fulfil children's rights, giving special attention to OVC and HIV/AIDS, in a protracted and deepening humanitarian situation. The programme will run over a two-year period and be reviewed annually to ensure that it responds to the changing macroenvironment and adapts appropriately. Based on the programme strategy's success in previous country programme implementation, it will be adapted to the new programme at two levels.

23. First, at the community level, UNICEF will support development of the capacity of vulnerable households and communities to reduce the vulnerability of OVC and promote their access to basic social services and sustainable livelihoods. Efforts will focus on a holistic approach, encompassing all facets and stages of a child's life. This assistance will focus on 18 districts that will act as innovative models, with at least one district from each of the 10 provinces covered. Criteria for district selection are based on high levels of the number of orphans, prevalence of sexually transmitted diseases as a proxy for HIV/AIDS, child population and poverty. Second, at the national level, UNICEF will advocate for national policies, strategies and legal and institutional reforms that ensure realization and monitoring of child rights in general, with emphasis placed on OVC and HIV/AIDS. Delivery of critical national-level services, including immunization and education, will continue.

24. Key expected results will include a reduction in the rate of children being orphaned; access to, and gender equity in, quality basic health care and education for 1 million orphans; and a reduction in the stigmatization of and discrimination against orphans, and in the incidence of HIV and child abuse.

Relationship to national priorities and the UNDAF

25. The country programme links together national priorities for United Nations assistance articulated in the Zimbabwe Millennium Development Goals progress report, draft CCA and UNDAF, National Economic Revival programme and various policy and legal documents. The documents include the 2003 National Plan of Action for OVC, the 2004 Health Revival Action Plan, the National HIV/AIDS Policy and Strategic Framework and the 2004 Gender Policy.

Relationship to international priorities

26. The programme's foundation is the Convention on the Rights of the Child, the Convention on the Elimination of All forms of Discrimination against Women, and the African Charter on the Rights and Welfare of the Child. The programme addresses the five UNICEF organizational medium-term strategic plan (MTSP) priorities, the five priorities of the Eastern and Southern African Regional Leadership Agenda, *A World Fit for Children* Plan of Action and the child-related Millennium Development Goals, emphasizing OVC and fighting HIV/AIDS.

Programme components

Child learning and lifeskills programme

27. With special focus on education of OVC, the programme seeks to (a) increase the primary school enrolment of girls and boys; (b) reduce drop-out rates related to the school environment; (c) improve the quality and relevance of education; (d) reduce the gender gap in basic education; (e) incorporate life and survival skills in primary education; and (f) contribute to the national policy-review process on education. Linkages will be forged between the work done regarding violence in and around schools, school water and sanitation and birth registration in the 18 districts and the WFP school feeding. The main focal partners will be the Ministry of Education, Sports and Culture and the Ministry of Technical and Higher Education.

28. UNICEF will promote broad partnerships for OVC-friendly education policy reform that promotes inclusion and non-discrimination and ensures equitable and gender-sensitive access, completion and learning achievement in education. Emphasis will be placed on home- and community-based initiatives that develop institutional, district and centre-based capacities in quality early childhood education and care and that enable orphans to enrol in and complete their education. UNICEF will encourage the participation of parent-teacher committees, caregivers and OVC in school governance and HIV/AIDS-prevention, and will seek alternative education opportunities for children as a way to prevent sexual abuse.

29. Curricula review and consolidation of quality formal and complementary educational opportunities for OVC that are based on lifeskills and livelihood skills will be advocated. To preserve human resources in education, teachers will be mobilized to access appropriate HIV/AIDS-prevention and care services, especially to access ARVs through their workplaces. Gender will be mainstreamed, especially through the provision of gender-disaggregated data, the promotion of early, positive gender-socialization, the assurance of the safety and security of girls attending

school, the prevention of sexual and economic exploitation, efforts to address the direct and opportunity costs of schooling, and working with teachers to reduce their inhibitions in discussions of sex and sexuality in the context of HIV/AIDS education. UNICEF will also provide support to analyse trends in orphan education and to monitor learning outcomes.

The health, nutrition and environment programme

30. The programme will contribute to the objectives of the National Health Sector Revival Action Plan to reduce infant, child and maternal mortality caused by preventable childhood illnesses, malnutrition and reproductive health problems. The programme's focal points are the Ministry of Health and Child Welfare, the National Aids Council, the Food and Nutrition Council, the Ministry of National Housing and Local Government and Rural Development Councils.

31. Within the framework of IMCI and Roll Back Malaria, UNICEF will support immunization coverage of all antigens, as well as vitamin A supplementation, and the prevention and control of malaria and other childhood diseases. The objectives are to: (a) increase immunization coverage for all antigens to 80 per cent, and routine vitamin A supplementation from 46 to 70 per cent; (b) maintain the eradication of polio and elimination of neonatal and maternal tetanus; and (c) increase to 30 per cent the coverage rate of insecticide-treated nets and prompt treatment of malaria in endemic districts for OVC and pregnant women.

32. UNICEF inputs will include procurement and distribution of vaccines, supplies, and essential drugs to support home-based treatment of childhood illnesses and training of facility and community health workers. UNICEF will provide technical assistance for reviews, studies, monitoring, and evaluations.

33. To help to prevent women from dying and leaving orphans behind, UNICEF will complement the work of the United Nations Population Fund (UNFPA) and WHO in providing emergency obstetric care, including referral of cases and prevention and treatment for malaria, and good nutrition. In support of the WHO "3 x 5" antiretroviral treatment, UNICEF will mobilize efforts for increased uptake and coverage of voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) of HIV. UNICEF will also advocate with the Government, WHO, UNAIDS, communities and other stakeholders to prioritize certain population groups in treatment, especially the mothers, spouses and children enrolled in the PMTCT programmes. Additional UNICEF inputs will include supplies, essential drugs, ARVs, the training of health workers and technical support to monitor and access global funds.

34. Support to improved nutrition will emphasize OVC, households and communities affected by HIV/AIDS. Infant and young child feeding will link with community IMCI, PMTCT, VCT, outreach community-based nutrition care and ARV treatment. The control and elimination of deficiencies of vitamin A, iodine and iron, including iron-deficiency anaemia, will be revamped. UNICEF will support the development of nutrition surveillance systems. Community-based growth monitoring will emphasize development of community capacity for improving the nutrition status of OVC and drive the 'triple A' processes in the 18 convergent districts. The development of a nutrition and childcare policy and strategy with defined outcomes for OVC will be supported. Through partnership work-plans with WFP, UNICEF will support therapeutic and supplementary feeding, assist in training and monitoring in school feeding and advocate for fortification of food aid.

35. UNICEF will contribute to the promotion of universal access to and utilization of safe water and basic sanitation, and the development of coherent national policies, strategies and guidelines responsive to the challenges posed by poverty and the HIV/AIDS and orphan crises. Emphasis will be on developing capacity for community and school participatory health, hygiene and sanitation education as well as management of water and waste systems in rural and peri-urban areas. Efforts will focus on households and communities affected by HIV/AIDS, including those with OVC. To improve the school environment for girls, UNICEF will support water and sanitation facilities and develop teacher capacity to inform students about water, hygiene and sanitation. Possibilities will be explored to use such support as block grants for the education of OVC. UNICEF will also broaden partnerships with the public sector, donors and NGOs to develop community and district capacities for preparedness and response to outbreaks of disease, such as cholera and malaria, that are caused by unsafe water and poor sanitation.

The child protection programme

36. The programme will collect and disseminate to stakeholders lessons learned and best practices that enhance the effectiveness of child protection interventions and will advocate, and mobilize and convene partners for, large-scale response to the challenges facing OVC. The Ministry of Public Service, Labour and Social Welfare will be the main focal point within the framework of the National Plan of Action for OVC and the Global Partners Forum for Children Orphaned and made Vulnerable by HIV/AIDS. Other ministries will include Justice, Legal and Parliamentary Affairs and Youth, Gender and Employment Creation.

37. Focusing on the 18 districts, UNICEF will support Rural District Councils, local leaders and community-based organizations to develop the capacities of families and households to improve the conditions of OVC. Developed capacities should help to improve economic conditions; provide psychosocial support and counselling of caregivers and abused children; prolong the lives of parents; support succession planning; facilitate integrated care; and develop young people's life and survival skills. To strengthen community-based responses to the problems faced by OVC, UNICEF will support social mobilization that encourages open discussion on HIV/AIDS and promotes cooperative activities and care of children having no family support. Moreover, for OVC, UNICEF will advocate for and promote free and compulsory education, birth registration, access to health and nutrition services; safe water and basic sanitation services; administration of justice; placement services for children without family care; and incorporation of OVC in local and district plans and actions.

38. At the national level, UNICEF will advocate for continued Government protection and resource-allocation for OVC, and also advocate for enforcing the supportive legislative framework. UNICEF will support the National Task Force on Street Children to address the problems faced by children who live or work on the street. To contribute to the national coordination mechanism for the National Plan of Action for OVC, UNICEF will continue to provide technical and financial support to the national secretariat and advocate for the accelerated establishment of similar mechanisms at the district level. For continued awareness-raising and creation of a supportive environment for OVC, UNICEF will assist ongoing efforts in participatory assessment and analysis of the situation of OVC. Partnerships formed during the rapid OVC assessment in 2004 will be maintained. These include partnerships with USAID, WFP, UNAIDS, the Support to Replicable Innovative Community/Village Level Efforts for Children Affected by HIV/AIDS (STRIVE)

programme of the Catholic Relief Services, and the Futures Group International, formed during the rapid OVC assessment in 2004. Support will be provided to the Inter-Ministerial Committee on Human Rights to address the rights of children and women. Support will also be provided to achieving timely reporting on the Convention on the Rights of the Child, on the Convention on the Elimination of All Forms of Discrimination against Women and on the African Charter on the Rights and Welfare of the Child.

The HIV/AIDS and young people development programme

39. This programme will collect and disseminate to stakeholders lessons learned and best practices that enhance the effectiveness of interventions preventing the spread of HIV and strengthening the care of those affected by AIDS while mitigating their suffering and challenges. Within the UNAIDS and UNDAF joint programming, UNICEF will advocate, and mobilize partners for, large-scale response to the HIV/AIDS challenge. UNICEF will emphasize integration of HIV/AIDS in the other sectors and programmes, and the development of partnerships. The objectives will be to (a) identify new knowledge and document best practices and lessons, facilitating their use for programmatic and policy response; (b) provide technical inputs into national tracking and critical analysis of the epidemic in order to have a better understanding of its epidemiological nature. This assessment will cover cultural practices and cross-border migration and will involve possible collaboration with other UNICEF offices in neighbouring countries; (c) support leveraging of global resources, such as those of the Global Fund on HIV/AIDS, Tuberculosis and Malaria, for large-scale response; and (d) develop strategies for participatory youth programming. The main counterparts will be the Ministry of Health and Child Welfare and the National AIDS Council.

40. UNICEF will advocate for institutionalization of the successful community-based counselling and for modifying intergenerational cultural and religious norms and practices that fuel the spread of HIV. Since youth are particularly vulnerable to HIV infection, UNICEF will support the development of policies and strategies that facilitate greater participation of young people in prevention activities. This will include support to peer counselling; promotion of multi-purpose community-based youth centres; increasing the number of primary and secondary schools with youth clubs for strengthening lifeskills; and the encouragement of youth-to-youth programmes through sports.

Cross-sectoral costs

41. The programme support component will cover recurrent costs, including salaries, utility costs, relevant salaries and security to ensure compliance with the United Nations Minimum Operating Security Standards.

42. The social policy analysis and rights monitoring, evaluation and research unit will seek to: (a) provide an ongoing analysis of the macroenvironment for children and women and its implications for various policies, including laws on OVC; and (b) facilitate linkages with UNDAF and national sector policies, strategies and plans. The unit will also facilitate the implementation of the monitoring, evaluation and programme management described below.

43. The communication unit will coordinate UNICEF advocacy for OVC and HIV/AIDS. Advocacy will reinforce the success of the country programme objective by creating a better understanding of the situation of OVC, highlighting what can be done and helping to ensure that all stakeholders, both national and international, are

fully committed to confronting HIV/AIDS and the orphan crisis. Communications initiatives will be developed and carried out in collaboration with a number of different partners, especially other United Nations agencies, Government line Ministries and UNICEF National Committees. The approach will seek to create stronger political leadership on the issue of OVC and HIV/AIDS, educate donor and other partners on worthwhile initiatives and translate this into more funding for these programmes. Emphasis will be placed on public engagement to propel and maintain the commitment of policy makers, politicians, donors, the private sector, civil society groups and other partners to fulfilling their obligations to OVC.

Major partnerships

44. The main partner is the Government of Zimbabwe, through its 10 Ministries, and other partners represented in the Programme Development and Monitoring Committee (PDMC). At the community level, crucial partners include the Rural Development Councils and increasingly community-based NGOs and faith-based organizations. UNICEF will also forge partnerships with civil society, children's networks, orphans and organizations dealing with children's issues, and with other United Nations agencies through the UNDAF. Of critical importance is the deepening and broadening of partnerships with donors who will fund the programme.

Monitoring, evaluation and programme management

45. The monitoring framework will be the Integrated Monitoring and Evaluation Plan and UNDAF results matrix. In collaboration with the Central Statistics Office and United Nations working group on data for development, UNICEF will use *DevInfo* to contribute to the development of a national database for children and women. To arrive at a common analysis and provide the basis for further development of programme interventions, UNICEF will support a systematic national research agenda on children and women, using local and international expertise. This will include the 2005 Demographic and Health Survey, Poverty Assessment Studies and scaling up of the village registers. Moreover, UNICEF will conduct regular field visits and mid-year and annual reviews.

46. The PDMC, co-chaired by the Ministry of Finance and the UNICEF Representative, will manage the programme. Biannual meetings held in the UNICEF 18 converge districts will allow for field visits of half a day each to communities. In addition to the 10 Ministries, PDMC members comprise two national autonomous organizations and two non-governmental organizations (NGOs). To ensure linkage with the UNDAF, the PDMC in its 2003 annual meeting approved widening its membership to include other United Nations agencies in addition to UNICEF, as well as key donors, to improve their understanding of and participation in the country programming process. Internal management take place will be through monthly meetings of the country management team and the programme management team.